

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10896

CERTIFICATE OF DEATH

10896

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN lb <b>Elkton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital Of Cecil County</b>		d. STREET ADDRESS <b>R.D.3 (rural)</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		07-1	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James L. Alexander</b>		4. DATE OF DEATH Month Day Year <b>August 2, 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1917</b>
9. AGE (In years lost birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>50</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lloyd James</b>		14. MOTHER'S MAIDEN NAME <b>Cora Richardson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>212-28-9374</b>	
17. INFORMANT <b>Bessie Alexander-Elkton, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Attack</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>3- Years</b> <b>3- Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/28/67</b> , 19 <b>67</b> , to <b>8/2/67</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>8/2/67</b> , 19 <b>67</b> , and that death occurred at <b>7 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>James L. Johnson</b>		22b. DATE SIGNED <b>8/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James L. Johnson M.D.</b>		22d. ADDRESS <b>245 E. High, St., Elkton Cecil Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/8/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Griffith Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cedar Hill, Md.</b>	
24. FUNERAL DIRECTOR <b>Charles R. Bell</b>		25a. REC'D BY REGISTRAR <b>909 Poplar Street</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 10 1967</b>	

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10897

## CERTIFICATE OF DEATH

10897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 1 Wk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS Elkton RD# 4			
3. NAME OF DECEASED (Type or print) First Earl Middle H. Last Anderson				4. DATE OF DEATH Month August Day 22, 1967 Year 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 19, 1901	
				9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worked in paper mill				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME L.W. Anderson				14. MOTHER'S MAIDEN NAME Sarah Hash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Bessie Anderson Address Elkton, Md. RD# 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 Pulmonary Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac arrhythmia DUE TO (c) dilated & fibrillated Heart							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis & pulmonary emphysema							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/16, 19 67 to 8/22, 1967 that I last saw the deceased alive on 8/22, 19 67, and that death occurred at 5 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE J.R. Ross				ADDRESS (Street, city or town, state) MEDICAL		DATE SIGNED	
PHYSICIAN'S NAME (Type) I R ROSS M.D.				Elkton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/67		22c. NAME OF CEMETERY OR CREMATORY Ott's Chapel Cem.		22d. LOCATION (City, town, or county) (State) Newark, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE R. T. Jones				ADDRESS Newark, Delaware		24a. REC'D BY REGISTRAR DATE AUG 25 1967	
				24b. REGISTRAR'S SIGNATURE Charles Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH August 22, 1927	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION None		7. MARITAL STATUS Single		8. EDUCATION High School	
9. PRESENT ADDRESS Room 303, 505 North Main St., Memphis, Tenn.		10. DATE OF DEATH April 4, 1968		11. TIME OF DEATH 2:01 PM		12. PLACE OF DEATH Memphis, Tennessee	
13. CAUSE OF DEATH FIRE		14. MANNER OF DEATH Accident		15. MEDICAL HISTORY None		16. PREVIOUS ILLNESS None	
17. SIGNATURE OF PHYSICIAN J. Edgar Hoover		18. SIGNATURE OF CORONER J. Edgar Hoover		19. SIGNATURE OF WITNESS J. Edgar Hoover		20. SIGNATURE OF DECEASED J. Edgar Hoover	

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10898			
CERTIFICATE OF DEATH			
10898			
1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>1 yr 3 mos</b>		d. STREET ADDRESS <b>239 Blakeney Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR WILSON BARRETT</b>		4. DATE OF DEATH <b>August 17 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-25-00</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>17</b> Days <b>19</b> Hours <b>67</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surveyor retired</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa.</b>	
13. FATHER'S NAME <b>Allen Barrett (D)</b>		14. MOTHER'S MAIDEN NAME <b>Adeline Mellor (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>219-16-8053</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4200</b> IMMEDIATE CAUSE (a) <b>Pulmonary emboli of both lower lobes with recent infarction and right artelectasis</b> (b) <b>Arteriosclerotic heart disease, severe</b> (c) <b>Arteriosclerotic heart disease, severe</b> Interval between onset and death <b>1 hr-1 day</b> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a.m.</b> Month <b>19</b> Day <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>May 9</b> , 19 <b>66</b> , to <b>Aug. 17</b> , 19 <b>67</b> that (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) and that death occurred at <b>10:15</b> am from causes and on the date stated above.			
22a. SIGNATURE <b>Gladys Ocejjo M.D.</b>		22b. DATE SIGNED <b>8-18-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>GLADYS OCEJO, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>8/21/67</b>	23b. DATE THEREOF <b>BURIAL</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE Md</b>
24. FUNERAL DIRECTOR <b>MacNabb &amp; Son Funeral Home, Frederick &amp; Wadsworth Ave., Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10899

10899

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN Tb 9yrs-10mos-7days Chatham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS 11 Hedges Ave.,	
3. NAME OF DECEASED (Type or print) Sue First Middle Last		4. DATE OF DEATH August 18, 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-94
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) housewife		12. KIND OF BUSINESS OR INDUSTRY -	
13. FATHER'S NAME John Yancy Rainer (Deceased)		14. MOTHER'S MAIDEN NAME Alice Anderson (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-20-69-37	
17. INFORMANT VA Hospital Records - Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, acute severe DUE TO (b) Broncho pneumonia, right lung DUE TO (c) Arteriosclerotic Coronary Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 - 6 hrs 2-6 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 10 11 57, 19, to 8 18 67, 19, and that death occurred at 8:45 M, from causes and on the date stated above.			
22a. SIGNATURE J. R. Garcia M.D.		22b. DATE SIGNED 8 19 67	
22c. PHYSICIAN'S NAME (Type) JACQUIN GARCIA, M.D.		22d. ADDRESS VA Hospital - Perry Point, Ma.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8-21-1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. Co.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ADDRESS PATTERSON FUNERAL HOME - PERRYVILLE, MARYLAND		25a. REC'D BY REGISTRAR DATE AUG 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

10900

CERTIFICATE OF DEATH

10900

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb D.O.A. ELKTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RITA MAY		4. DATE OF DEATH August 5, 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY, 4, 1914	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) ELKTON, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GORMAN HITCHENS		14. MOTHER'S MAIDEN NAME KATHREINE DICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 165-07-0926	
17. INFORMANT HARRISON N. BOWES, ELKTON, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary DUE TO (b) Chronic Myocarditis DUE TO (c) Arrested Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 4-Hours 3-Years 10-Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 008.2		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 6/23/67, 1967, to 8/5/67, 1967, that (I) (we) last saw the deceased alive on 8/5/1967, and that death occurred at 9:30 M. from causes and on the date stated above.			
22a. SIGNATURE Joseph L. Johnson		22b. DATE SIGNED 8/7/67	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 E. High St., Elkton Cecil Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-10-67	
23c. NAME OF CEMETERY OR CREMATORY IMMACULATE CONCEPTION		23d. LOCATION (City or Town) (County) (State) CHERRY HILL CECIL MD.	
24. FUNERAL DIRECTOR Robert Board		25a. REC'D BY REGISTRAR	
PIPTIN FUNERAL HOME - ELKTON, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE AUG 9 1967			

STATE OF NEW YORK

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

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FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

1. PLACE OF DEATH a. COUNTY <b>CECIL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ELKTON</b>		c. LENGTH OF STAY IN lb <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ELKTON</b>		<b>07-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MALONE ROAD</b>				d. STREET ADDRESS <b>MALONE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLYDE VINCENT</b>		First Middle Last <b>BROADWATER</b>		4. DATE OF DEATH Month <b>8</b> Day <b>14</b> Year <b>1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-27-10</b>	
9. AGE (In years lost birthday) <b>56</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATE ROAD COMM.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>HAUTE DE GRACE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W. BROADWATER</b>				14. MOTHER'S MAIDEN NAME <b>EMMA DEPPISH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-03-4494</b>		17. INFORMANT <b>VIOLET M. BROADWATER ELKTON, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMPHYSEMA</b> 5257 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>FIBROSIS OF LUNGS</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b> <b>3 YEARS</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 16, 1967</b> , to <b>AUG 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>AUG 12, 1967</b> , and that death occurred at <b>8:00 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Henry V. Davis</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/19/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>HENRY V. DAVIS MD</b>		22d. ADDRESS <b>CHESAPEAKE CITY MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-17-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ELKTON</b>		23d. LOCATION (City or town) (County) (State) <b>ELKTON CECIL MD.</b>	
24. FUNERAL DIRECTOR <b>PITPIN FUNERAL HOME</b>		ADDRESS <b>ELKTON, MD</b>		25a. REC'D BY REGISTRAR <b>AUG 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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FROM: [illegible]  
SUBJECT: [illegible]  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
10902									
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN lb <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital, Perry Point, Md.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b> d. STREET ADDRESS <b>Elm Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis Leon Campbell</b>					4. DATE OF DEATH Month Day Year <b>August 31 19 67</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>3-26-26</b>		9. AGE (In years last birthday) yrs. <b>41</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Industry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Perryville, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Albert Campbell</b>					14. MOTHER'S MAIDEN NAME <b>Wanda Stebbing</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>214-20-2424</b>		17. INFORMANT Address <b>VA Hospital Records, Perry Point, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal carcinoma - Floor of mouth</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>August 31, 19 67</b> , to <b>August 31, 19 67</b> , and that death occurred at <b>8:35 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>J. P. BLANCAFLOR</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8 9/1/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>VAH, Perry Point, Maryland</b>				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/3/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <b>North East (Cecil) Maryland</b>			
24. FUNERAL DIRECTOR <b>Lee A. Patterson &amp; Son, Perryville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 6 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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Figure 1

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10903

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10903

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Trout Dale</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN lb <b>15 MIN.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOESPH E. CHATHAM</b>		4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-11-06</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	11. BIRTHPLACE (State or foreign country) <b>V.A.</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN CHATHAM</b>		14. MOTHER'S MAIDEN NAME <b>NO INFO.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>EMMA MAE CHATHAM</b>		Address <b>TROUT DALE V.A.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		22. DATE SIGNED <b>August 28, 1967</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		23. LOCATION (City or Town) (County) (State) <b>TROUT DALE V.A.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-31-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CORNERS CREEK</b>		23d. LOCATION (City or Town) (County) (State) <b>TROUT DALE V.A.</b>	
24. FUNERAL DIRECTOR <b>PIPPIN FUNERAL HOME</b>		25. REC'D BY REGISTRAR <b>Aug 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>		25c. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

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## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

10904

10904

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North East, Md.</u> c. LENGTH OF STAY in lb <u>2 mo. 5 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>224 East Main St.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North East</u> d. STREET ADDRESS <u>R.D. 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>8 26 1967</u> Month Day Year				
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Nov. 11, 1892</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Lancaster Co. Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>William Singleton</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Norman A. Cornell</u> Address <u>R.D. 2 North East, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C-V disease</u> (b) <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Parkinson's disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 21, 1967</u> , to <u>August 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 25, 1967</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>S. RAYH ANDREWS, JR.</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>S. RAYH ANDREWS, JR.</u>			<b>22b. DATE SIGNED</b> <u>10/26/67</u> <b>22d. ADDRESS</b> <u>221 E MAIN ST. - ELKTON, MARYLAND</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>8-29-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Brookview Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) (State) <u>Rising Sun, Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Paul P. Cranch</u> <u>Grant Funeral Home</u> Box 22 North East, Md.					
<b>25a. REC'D BY REGISTRAR</b> <u>AUG 29 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 is retained by the hospital or attending physician. Page 2 of 2 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

WASHINGTON

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Mary

Cornell

Nov. 1, 1892

Home

Unknown

William Jackson

R. U. S.  
North East, Md.

William A. Cornell

Home

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North East, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10905

10905

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>8 mo. 4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph DAVIS</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-5-10</b>
9. AGE (In years last birthday) yrs. <b>57</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>13</b> Hours <b>13</b> Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Cleaner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nashville, Tenn</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wyatt Davis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Head</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>406-05-06-94</b>	
17. INFORMANT <b>VA Hospital Records - Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia right lower lobe</b> 4200 DUKKO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Emphysema, severe of both lungs</b> (c) <b>Arteriosclerotic heart disease</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>10-15 days</b> Years Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> (this hospital) attended the deceased from <b>12-9-66</b> , 19 <b>pm</b> <b>8-13-67</b> , 19 <b>pm</b> <b>8-13-67</b> , and that death occurred at <b>5:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Seymour Goldgraben</b>		22b. DATE SIGNED <b>8-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Seymour Goldgraben, M.D.</b>		22d. ADDRESS <b>VA Hospital - Perry Point, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/18/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		23d. LOCATION (City or Town) (County) (State) <b>Landover, Maryland</b>	
24. FUNERAL DIRECTOR <b>Jarvis Funeral Home</b>		25a. REC'D BY REGISTRAR <b>AUG 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

District of Columbia

Local

Washington

8 mo. 4 days

Point Point

1418 12th St., N.W.

VA Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/64

10906

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10906

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN lb <b>3 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Elkton</b>		d. STREET ADDRESS <b>R.D. 4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ray Richard Dean</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18, 1912</b>
9. AGE (In years lost birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Mm.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Concrete</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pocahontas Co. W Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edgar W. Dean</b>		14. MOTHER'S MAIDEN NAME <b>Pearl E. Cuttipe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-16-1626</b>	
17. INFORMANT <b>Charles B. Dean</b>		Address <b>R.D. 2 North East, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4201 Myocardial Infarction</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>24 hours</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Subtotal Gastrectomy on 8-2-67.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-1-1967</b> , to <b>8-3-1967</b> , that (I) (we) last saw the deceased alive on <b>8-3-1967</b> and that death occurred at <b>9:40 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Cristobal Vela</b> M.D.		22b. DATE SIGNED <b>8-3-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CRISTOBAL VELA</b>		22d. ADDRESS <b>123 W. High St. Elkton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-7-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Mem. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Elkton Cecil Md.</b>	
24. FUNERAL DIRECTOR <b>Paul R. Crutch</b>		25a. REG. B. REGISTRAR <b>AUG 7 1967</b>	
Grant Funeral Home		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

AUG 7 1967

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CERTIFICATE OF DEATH

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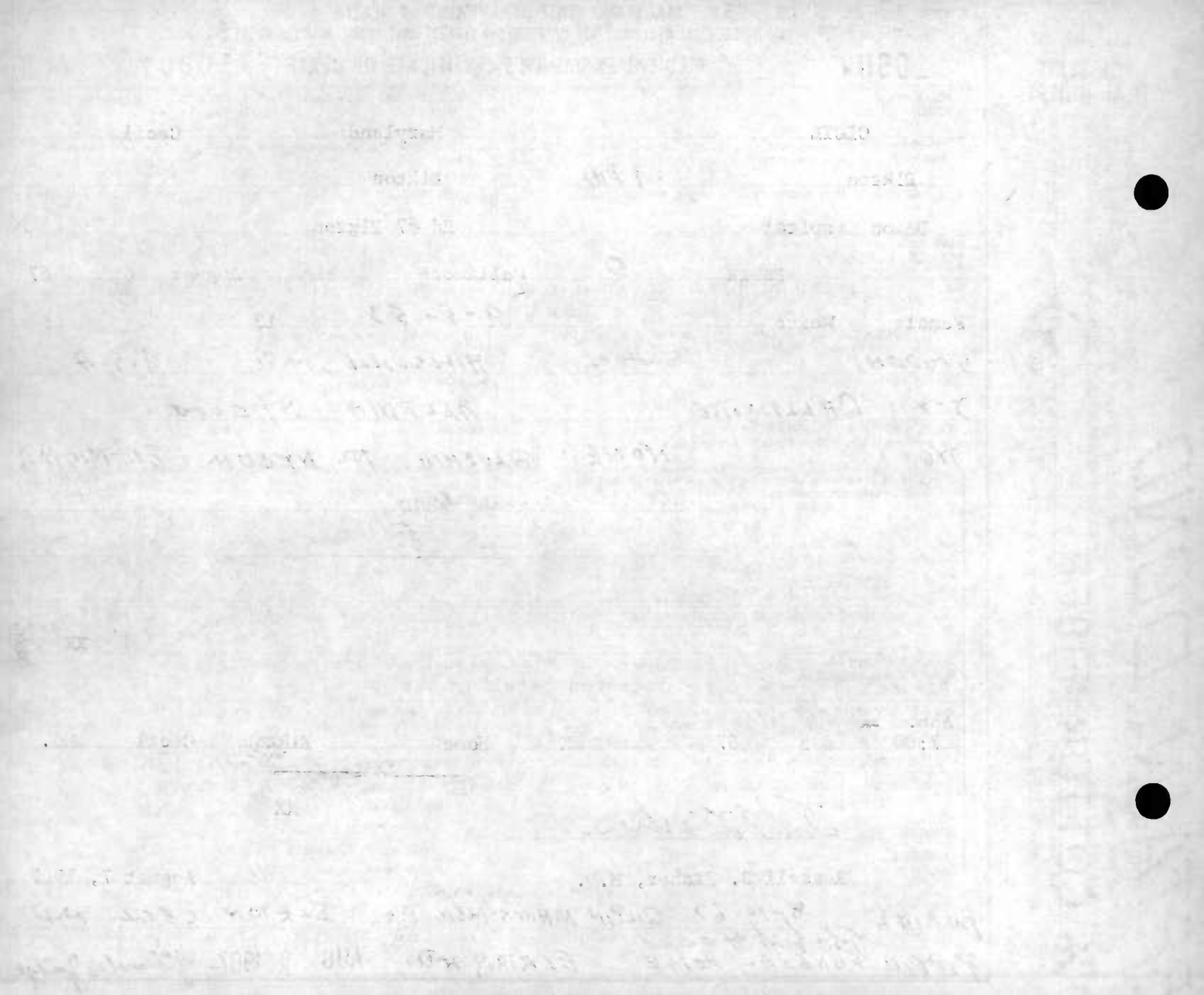
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
10907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10907										
1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>					d. STREET ADDRESS <b>Rd #7 Elkton</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>BESSIE O. Gallimore</b>					4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-5-53</b>		9. AGE (In years lost birthday) yrs. <b>13</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>			11. BIRTHPLACE (State or foreign country) <b>HILLSVILLE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOHN GALLIMORE</b>					14. MOTHER'S MAIDEN NAME <b>ALVENIA NYCUM</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ALVENIA M. NYCUM</b> Address <b>ELKTON, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>970.2 IMMEDIATE CAUSE (a) Barbiturate ingestion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ingested barbiturates</b>						
20c. TIME OF INJURY Month, Day, Year <b>App. Hour 7:00 p.m. 8 5 19 67</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Elkton Cecil Md.</b>		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Noturol causes</b> <input type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input checked="" type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined monner</b> <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					22. DATE SIGNED <b>August 7, 1967</b>
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county)					Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>8-10-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GILPIN MAJOR MEN. PK.</b>			23d. LOCATION (City or Town) (County) (State) <b>ELKTON CECIL MD.</b>		
24. FUNERAL DIRECTOR <b>PIPPIN FUNERAL HOME</b>					ADDRESS <b>ELKTON MD</b>		25a. REC'D BY REGISTRAR <b>AUG 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10908

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10908

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>JEFFERSON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHARLESTOWN - RURAL</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNION HOSPITAL</b>		d. STREET ADDRESS <b>STILES TRAPER COURT</b>	
3. NAME OF DECEASED (Type or print) <b>PERLE MASON GEORGE</b>		4. DATE OF DEATH Month <b>AUG</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 24 - 1918</b>
9. AGE (In years, last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RYO RAILROAD</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES GEORGE</b>		14. MOTHER'S MAIDEN NAME <b>LUCRETIA MAYLES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. F.M. GEORGE</b>		Address <b>CHARLESTOWN W.VA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>CHRONIC CORONARY DISEASE</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>17-18</b> <b>SEVERAL YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL OVER AT HOME SHORTLY AFTER EATING</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:25 p.m. 8/13/67</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>AT HOME OFFSHORE</b>	20f. (City or town) (County) (State) <b>ELKTON CECIL MD</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Henry U. Davis</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>HENRY U. DAVIS M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>AUG. 14, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <b>CHARLESTOWN, W. VA.</b>	
24. FUNERAL DIRECTOR <b>PIPPIN FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>AUG 15 1967</b>	
ADDRESS <b>ELKTON, MD</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Peak</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>42 yrs 45 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegheny</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>219 Maryland Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>GELSON L. GRADY</b>			4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>1967</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>5-20-95</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Michael Grady (D)</b>		14. MOTHER'S MAIDEN NAME <b>Ella Wright (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>217-54-9846</b>		17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>June 27</b> , 19 <b>65</b> , to <b>Aug. 1</b> , 19 <b>67</b> , and that death occurred at <b>2:25</b> M. from causes on and on the date stated above. 22a. SIGNATURE <b>A.L. Mooney</b> 22b. DATE SIGNED <b>8-2-67</b> 22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D.</b> 22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 4, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR <b>PATTERSON FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>AUG 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-37107)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [REDACTED]

RE: [REDACTED]  
DATE: 11-15-77  
BY: [REDACTED]

1. [REDACTED]  
2. [REDACTED]  
3. [REDACTED]

4. [REDACTED]  
5. [REDACTED]  
6. [REDACTED]

7. [REDACTED]  
8. [REDACTED]  
9. [REDACTED]

10. [REDACTED]  
11. [REDACTED]  
12. [REDACTED]

13. [REDACTED]  
14. [REDACTED]  
15. [REDACTED]

16. [REDACTED]  
17. [REDACTED]  
18. [REDACTED]

19. [REDACTED]  
20. [REDACTED]

10910

Item #2c Film #G392 8/29/67 ph

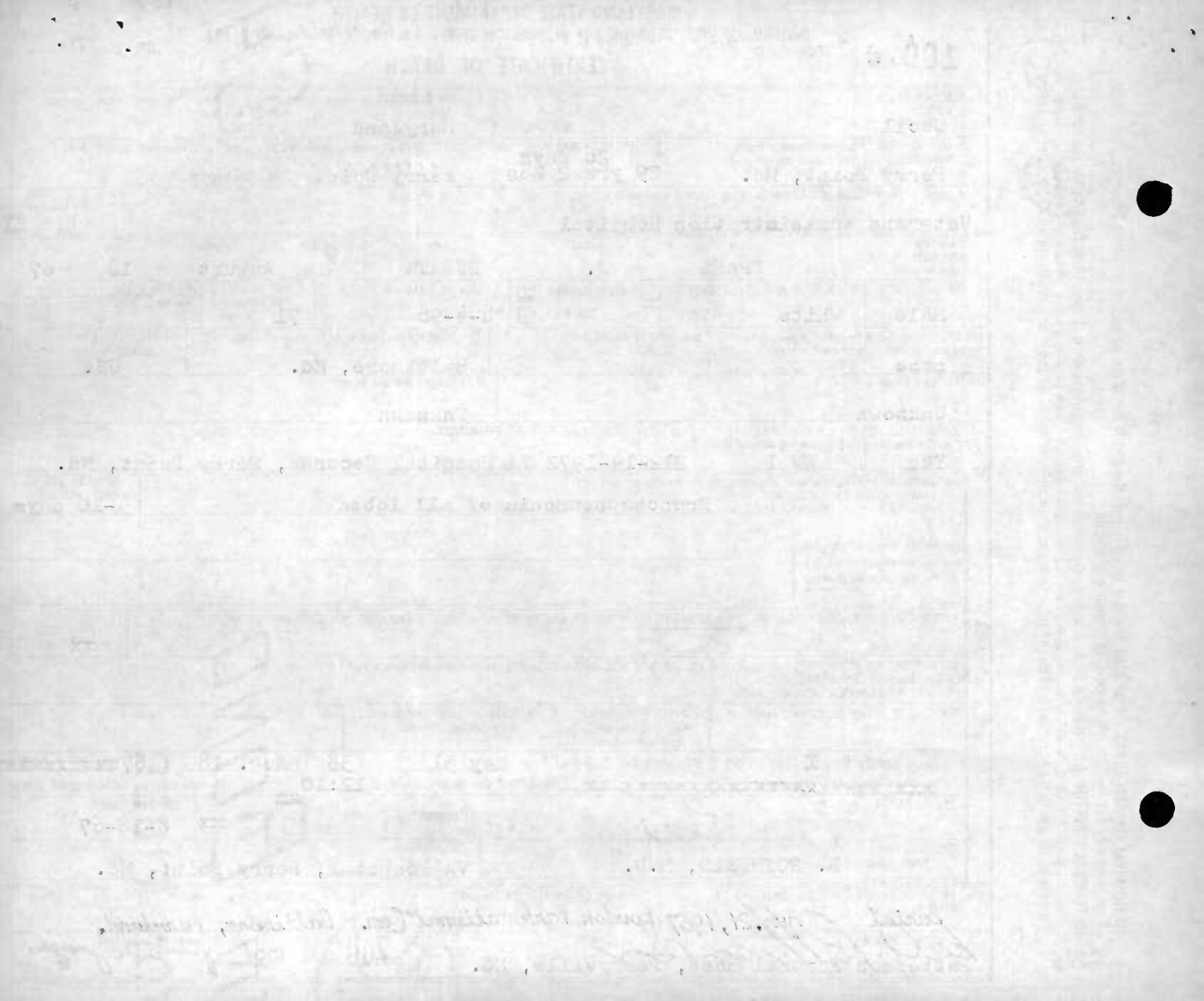
## CERTIFICATE OF DEATH

10910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b> c. LENGTH OF STAY in 1b <b>29 yrs 2 mos</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Perry Point / Baltimore</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRANK J. HUBATA</b>		4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-4-96</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>212-14-1972</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia of all lobes</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 31</b> , 19 <b>38</b> , to <b>Aug. 18</b> , 19 <b>67</b> , and that the deceased gave <del>no</del> <b>no</b> history of <del>any</del> <b>any</b> <del>other</del> <b>other</b> <del>causes</del> <b>causes</b> , and that death occurred at <b>12:10</b> <b>am</b> from causes and on the date stated above.			
22a. SIGNATURE <b>B. Rothfeld</b>		22b. DATE SIGNED <b>8-18-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. ROTHFELD, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Patterson Funeral Home, Perryville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 24 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



10911

10911

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>28 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>28 8th Street, NE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALEXANDER JOHNSON</b>		4. DATE OF DEATH Month Day Year <b>August 23 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-23-12</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		9. AGE (In years lost birthday) yrs. <b>55</b>	10. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) <b>Orange Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Johnson (D)</b>		14. MOTHER'S MAIDEN NAME <b>Doretha Johnson (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>578-12-1936</b>	17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant cachexia</b> DUE TO (b) <b>Carcinomatosis</b> DUE TO (c) <b>Carcinoma of pancreas with metastasis</b> 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>1/2-1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour : o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>July 26</b> , 19 <b>67</b> , to <b>Aug. 23</b> , 19 <b>67</b> , that he died on <b>Aug. 23</b> , 19 <b>67</b> , at <b>6:05 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. L. Mooney</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>8/26/67</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>	23d. LOCATION (City or Town) (County) (State) <b>Pt. Ch. Md.</b>
24. FUNERAL DIRECTOR <b>John T. Rhines Funeral Home, Washington, DC</b>		25a. REC'D BY REGISTRAR <b>AUG 28 1967</b>	25b. REGISTRAR'S SIGNATURE <b>John T. Rhines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if a physician, within 72 hours after death.

1001

REMARKS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10912

CERTIFICATE OF DEATH

10912

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>NORMIRA</u>	
3. NAME OF DECEASED (Type or print) <u>CHESTER ARTHUR KENNEDY</u>		4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-82</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WIKES CO. N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NEWTON KENNEDY</u>		14. MOTHER'S MAIDEN NAME <u>JANE HALL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>200-10-5273</u>	
17. INFORMANT <u>JULIUS A. JODLBALER</u>		Address <u>ELKTON, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-3-</u> , 19 <u>67</u> , to <u>8-9-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-9-</u> , 19 <u>67</u> , and that death occurred at <u>2 A.</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Tillman D. Johnson</u>		22b. DATE SIGNED <u>8-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>		22d. ADDRESS <u>123 S. 1st Ave. Elkton</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-12-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROSE BANK</u>		23d. LOCATION (City or Town) (County) (State) <u>CELVERT CECIL MD.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Good</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
26. PIPPIN FUNERAL HOME <u>ELKTON, MD.</u>		27. DATE <u>AUG 14 1967</u>	

31007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10913

CERTIFICATE OF DEATH

10913  
(10913)

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>12 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON MD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>303 ELKTON BLVD</u>			
3. NAME OF DECEASED (Type or print) <u>HELEN</u> First <u>H.</u> Middle <u>MARGILLAN</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>74</u> yrs.	
9. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HO HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>CHARLES HAMILTON</u>			
14. MOTHER'S MAIDEN NAME <u>MARGARET FLOSSER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>203-03-5921</u>				17. INFORMANT <u>UNION HOSPITAL</u> Address <u>ELKTON MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A.</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE C.V. DISEASE</u> DUE TO (c) <u>10 DAYS</u> <u>SEVERAL YEARS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 10, 1967</u> to <u>AUG 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>AUG 17, 1967</u> , and that death occurred at <u>5:44 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Henry V. Davis</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS</u>				22d. ADDRESS <u>CHESAPEAKE CITY MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG. 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GILPIN MANOR MEM. PK.</u>		23d. LOCATION (City or Town) (County) (State) <u>ELKTON, CECIL MD</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME, Annapolis, Md</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10914 CERTIFICATE OF DEATH 10914									
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>			c. LENGTH OF STAY IN 1b <u>8 yrs, 11 m. 9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			12.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>					d. STREET ADDRESS <u>22 Alton Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SCHUYLER C. MARSHALL</u>					4. DATE OF DEATH Month Day Year <u>August 30 1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-25</u>		9. AGE (In years last birthday) yrs. <u>41</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chaplain</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Army</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Patterson, New Jersey</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Schuyler Marshall</u>					14. MOTHER'S MAIDEN NAME <u>Rachel Wilson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>			16. SOCIAL SECURITY NO. <u>150-12-1781</u>		17. INFORMANT Address <u>VA Hospital Records, Perry Point, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4331</u> IMMEDIATE CAUSE (a) <u>Probable Ventricular Fibrillation</u> DUE TO (b) <u>Acute Myocardial Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Sudden</u> <u>Sudden</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <u>24</u> (this hospital) attended the deceased from <u>November 10, 1958</u> , to <u>August 30, 1967</u> , and that death occurred at <u>2:15am</u> from causes and on the date stated above.									
22a. SIGNATURE <u>A. L. Mooney</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8-30-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>A. L. MOONEY, M.D.</u>					22d. ADDRESS <u>VAH, Perry Point, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/31/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Md.</u>			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <u>Patterson Funeral Home, Perryville, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>SEP 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

72-07-8 92

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

M

MEDICAL CERTIFICATION

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John M. Byers, M.D.

CHIEF MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
Address (Street, city, town, or county)

22. DATE SIGNED  
8-12-67  
Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial  
23b. DATE THEREOF  
8-16-1967  
23c. NAME OF CEMETERY OR CREMATORY  
Anson Memorial Park Cem. Wadesboro, N. C.  
23d. LOCATION (City or Town) (County) (State)  
Wadesboro, N. C.  
24. FUNERAL DIRECTOR  
Lee A. Patterson & Son, Perryville, Maryland  
25a. REC'D BY REGISTRAR  
Charles Judge  
25b. REGISTRAR'S SIGNATURE  
AUG 16 1967

10915

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10915

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Port Deposit		c. LENGTH OF STAY IN lb minutes	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naval Training Center, Bainbridge		d. STREET ADDRESS Surface School Command	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Donald Robert Martin		4. DATE OF DEATH Month 8 Day 12 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-30
9. AGE (In years last birthday) yrs. 37		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Tender, U.S.N.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Wadesboro, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elim Martin		14. MOTHER'S MAIDEN NAME Elice Bell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Feb. 9, 1967-13 yrs.		16. SOCIAL SECURITY NO. 244-10-7870	
17. INFORMANT Health Record, U.S.-N. Training Center		Address Bainbridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8254 IMMEDIATE CAUSE (a) Crushing of Chest DUE TO (b) Automobile Accident DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Immed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pinned under car in one-car automobile accident.	
20c. TIME OF INJURY Hour 9:10 p.m. Month, Day, Year 8-12 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Craigtown Road		20f. (City or town) (County) (State) Hr. Port Deposit, Cecil, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED 8-12-67 Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-16-1967	
23c. NAME OF CEMETERY OR CREMATORY Anson Memorial Park Cem.		23d. LOCATION (City or Town) (County) (State) Wadesboro, N. C.	
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE AUG 16 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon/papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10916		10916	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. LENGTH OF STAY IN 1b <b>2 Mo 9 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital, Perry Point, Md.</b>		d. STREET ADDRESS <b>3701 S. 13th Street</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>F</b> Last <b>MASSEY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-12-98</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic - Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hampton, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Massey</b>		14. MOTHER'S MAIDEN NAME <b>Mary D. Foster</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>225-05-2741</b>	
17. INFORMANT <b>VA Hospital records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Atelectasis, Right Lung</b> DUE TO (b) <b>Metastatic Tumor nodule to Lungs, Bilateral</b> DUE TO (c) <b>Carcinoma of Esophagus.</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-3- Hrs</b> <b>Months</b> <b>1-2 Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 5</b> , 19 <b>67</b> , to <b>August 14</b> , 19 <b>67</b> , and that death occurred on <b>August 14</b> , 19 <b>67</b> , at <b>4:00 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. L. Mooney</b>		22b. DATE SIGNED <b>8-14-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D.</b>		22d. ADDRESS <b>VAH., Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Removal</b>	23b. DATE THEREOF <b>8/27/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Culpepper National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Culpepper, Virginia</b>
24. FUNERAL DIRECTOR <b>Murphy Fun</b>		25a. REC'D BY REGISTRAR <b>AUG 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Excluded, again, is the term "disaster."

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FOR STATE  
HEALTH DEPT.

10917

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10917

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			c. LENGTH OF STAY IN 1b <b>P.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenolden</b> 75-8		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>1130 Oadwood Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS McANDREW</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-20-22</b>		9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES REPRESENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SALES</b>		11. BIRTHPLACE (State or foreign country) <b>JESSUP PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES P. MC ANDREW</b>				14. MOTHER'S MAIDEN NAME <b>EVA KELLY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ANN MARIE WRIGHT GLENOLDEN, PA.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>August 25, 1967</b>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-29-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		23d. LOCATION (City or Town) (County) (State) <b>SCRANTON PA.</b>	
24. FUNERAL DIRECTOR <b>TIPPIN FUNERAL HOME</b>				25a. REC'D BY REGISTRAR <b>ELKTON, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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10918

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10918

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>		c. LENGTH OF STAY IN 1b <b>2 MONTHS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>		d. STREET ADDRESS <b>207 FRIENDSHIP ROAD</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA B. PRICE</b>		4. DATE OF DEATH Month <b>8</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-2-90</b>
9. AGE (In years lost birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRACTICAL NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NURSING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HOUGH</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MARGARET A. APPLEFORD, ELKTON, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Colon &amp; Metastases</b> 1532 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-29-</b> , 1967, to <b>8-17-</b> , 1967, that (I) (we) last saw the deceased alive on <b>8-17-1967</b> , and that death occurred at <b>10:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>T.D. Johnson</b>		22b. DATE SIGNED <b>8-18-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>T.D. Johnson</b>		22d. ADDRESS <b>103 Singler Ave, Elkton MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8-21-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GILPIN MANOR MEM. PR.</b>	23d. LOCATION (City or Town) (County) (State) <b>ELKTON CECIL MD.</b>
24. FUNERAL DIRECTOR <b>Robert J. Pappin</b>		25a. REC'D BY REGISTRAR <b>Aug 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Pappin</b>		26. DATE <b>AUG 21 1967</b>	

1001

CERTIFICATE OF DEATH

THE STATE OF TEXAS, COUNTY OF DALLAS, DECEASED

NAME OF DECEASED: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Coroner: [illegible]

Signature of Registrar: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN lb <b>104 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		d. STREET ADDRESS <del>1111 North 5th Street</del> <b>3037 North 5th Street</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>J.</b> Last <b>REILLY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 28 07</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roofer</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years and months) <b>60</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Reilly (D)</b>		14. MOTHER'S MAIDEN NAME <b>Mary Tireny (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>160-01-10-69</b>	
17. INFORMANT <b>VA Hospital Records - Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>H</b> (this hospital) attended the deceased from <b>4 25 67</b> , 19, to <b>8 7 67</b> , 19, that <b>H</b> (we) last <del>examined the deceased on</del> <b>10:15 PM</b> , and that death occurred <b>10:15 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>S. Goldcraben</b>		22b. DATE SIGNED <b>8 8 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>		22d. ADDRESS <b>VA Hospital - Perry Point, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-12-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillside Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Roslyn, Pa.</b>
24. FUNERAL DIRECTOR <b>Patterson Funeral Home, Perryville, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 11 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10920

CERTIFICATE OF DEATH

10920

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN ib <b>2 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		d. STREET ADDRESS <b>RD 4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W.</b> Last <b>SCHAIBLE</b>		4. DATE OF DEATH Month <b>August 10,</b> Day <b>19</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 14 97</b>
9. AGE (In years birth day) yrs. <b>70</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maint.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Board</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christian Schaible</b>		14. MOTHER'S MAIDEN NAME <b>Pauline----</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>215-01-14-96</b>	
17. INFORMANT <b>VA Hospital Records - Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, all lobes</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Heart Disease, severe</b> DUE TO (c) <b>Many years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>4</b> (this hospital) attended the deceased from <b>8-8-67</b> , 19 <b>8-10-67</b> , 19 <b>8-10-67</b> , and that death occurred at <b>7:55 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin Rothfeld</b>		22b. DATE SIGNED <b>8 11 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>BENJAMIN ROTHFELD, M.D.</b>		22d. ADDRESS <b>VA Hospital - Perry Point, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cherry Hill, Md.</b>
24. FUNERAL DIRECTOR <b>HICKS FUNERAL HOME - Elkton, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

REPORT OF DEATH

1000

Serial

Organization

Local

Rank

Age

Service Number

Unit

Medical

Date of Death

Place

By

Signature

Year

Month

Day

Time

U.S.A.

Branch

Grade

Post

Remarks

Remarks

1. Name of the deceased

2. Date of death

3. Place

4. Cause

5. Name of the commanding officer

6. Name of the medical officer

7. Name of the surgeon

8. Name of the assistant surgeon

9. Name of the medical orderly

10. Name of the medical assistant

11. Name of the medical clerk

12. Name of the medical sergeant

13. Name of the medical corporal

14. Name of the medical private

10921

## CERTIFICATE OF DEATH

10921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>4 days</b> <b>25 yrs 2 mos</b>		d. STREET ADDRESS <b>775 Fairmont St., NW</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD TURNER</b>		4. DATE OF DEATH Month Day Year <b>August 14 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-28-89</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>217-54-9829</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerosis, Generalized</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1-2- Wks</b> <b>Unkn</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Arteriosclerosis.</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>May 21, 1942</b> , to <b>Aug. 14, 1967</b> , and that death occurred at <b>9:45 am</b> on the date stated above.			
22a. SIGNATURE <b>A. L. Mooney</b>		22b. DATE SIGNED <b>8-14-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/18/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>Jarvis Funeral Home</b> ADDRESS <b>DC</b>		25a. REC'D BY REGISTRAR <b>AUG 16 1967</b>	
Jarvis Funeral Home, 1432 You St., NW, Wash.		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

ASB

10922

## CERTIFICATE OF DEATH

10922

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Del.</u> b. COUNTY <u>Newcastle</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>Summit Bridge</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>Middletown R.D.</u>	
3. NAME OF DECEASED (Type or print) First <u>CLAUDE</u> Middle <u>B.</u> Last <u>VOSNELL</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/16/94</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HARRY VOSNELL</u>		14. MOTHER'S MAIDEN NAME <u>LOUIE DAVIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-14-0095</u>	
17. INFORMANT <u>HOSP RECORDS</u>		Address <u>ELKTON MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>451X RUPTURED ABDOMINAL ANEURISM</u> DUE TO (b) <u>ARTERIO SCLEROSIS: GENERALIZED</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u> <u>SEVERAL YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>44</u> to <u>Aug 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 21</u> , 19 <u>67</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Henry U. Davis</u>		22b. DATE SIGNED <u>8/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY U. DAVIS</u>		22d. ADDRESS <u>CHESAPEAKE CITY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Chesapeake City, Md.</u>
24. FUNERAL DIRECTOR <u>G. Lester Daniels</u>		25a. REC'D BY REGISTRAR <u>Middletown Del.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 20 1967</u>	

100-100000

1. NAME (Last, First, Middle Initial)		2. GRADE	
3. TITLE		4. DUTY STATION	
5. DATE		6. PERIOD OF REPORT	
7. SUBJECT		8. SUMMARY OF REPORT	
9. ANALYSIS		10. CONCLUSIONS	
11. RECOMMENDATIONS		12. COMMENTS	

100-100000

1. NAME (Last, First, Middle Initial)  
2. GRADE  
3. TITLE  
4. DUTY STATION  
5. DATE  
6. PERIOD OF REPORT  
7. SUBJECT  
8. SUMMARY OF REPORT  
9. ANALYSIS  
10. CONCLUSIONS  
11. RECOMMENDATIONS  
12. COMMENTS

10923

CERTIFICATE OF DEATH

10923

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 21 days		d. STREET ADDRESS 38 Adams Street, N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLYDE ALLEN WARE		4. DATE OF DEATH Month Day Year August 9, 1967 19	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1925
9. AGE (In years last birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaping	
11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charlie Ware (D)		14. MOTHER'S MAIDEN NAME Ethel Ware (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 678-22-4874	
17. INFORMANT VA Records, VAH Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5811 DUE TO lower lobes (b) Pancreatitis, hemorrhagic, acute DUE TO Peripancreatic fat necrosis (c) Laennec's cirrhosis, severe			INTERVAL BETWEEN ONSET AND DEATH 2-4 days 2-4 days 2-4 days 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from July 19, 1967, to August 9, 1967, that (he/she) died on the date stated above, and that death occurred at 7:50 PM from causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 8-9-67	
22c. PHYSICIAN'S NAME (Type) S. Goldgraben, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md. 21902	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/14/1967	23c. NAME OF CEMETERY OR CREMATORY Harmony	23d. LOCATION (City or Town) (County) (State) Landover, Maryland
24. FUNERAL DIRECTOR Jarvis Funeral Home, Washington, DC		25a. REC'D BY REGISTRAR AUG 14 1967	25b. REGISTRAR'S SIGNATURE Charles J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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City of \_\_\_\_\_

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

10924

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10924

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Elkton		c. LENGTH OF STAY IN 1b 1 hour	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Elkton		d. STREET ADDRESS R.D. 1 (Rte. 7)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. 1 (Circus Park)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rickie Allen Whited		4. DATE OF DEATH 8 - 17 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-64
9. AGE (In years lost birthday) 3 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Whited		14. MOTHER'S MAIDEN NAME Helen Frances Cooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Trooper D.C. Hash, Md. State Police		Address North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9290 Asphyxia due to DUE TO Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Fell into septic tank pit, full of water (8' deep)	
20c. TIME OF INJURY Month, Day, Year 1215 p.m. 8-17 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard nr. home	
20f. (City or town) Rte. 7 (Circus Park) Cecil, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John M. Byers, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John M. Byers, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 8-17-67		Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/20/67	
23c. NAME OF CEMETERY OR CREMATORY Clinch Valley Cemetery		23d. LOCATION (City or Town) Richlands, Va.	
24. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	
AUG 24 1967			

April 2/1907 - Gifford Valley Cemetery, Richmond, Va.

Richmond, Va. 1907.

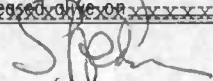
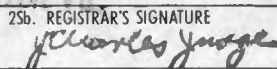
CERTIFICATE OF DEATH

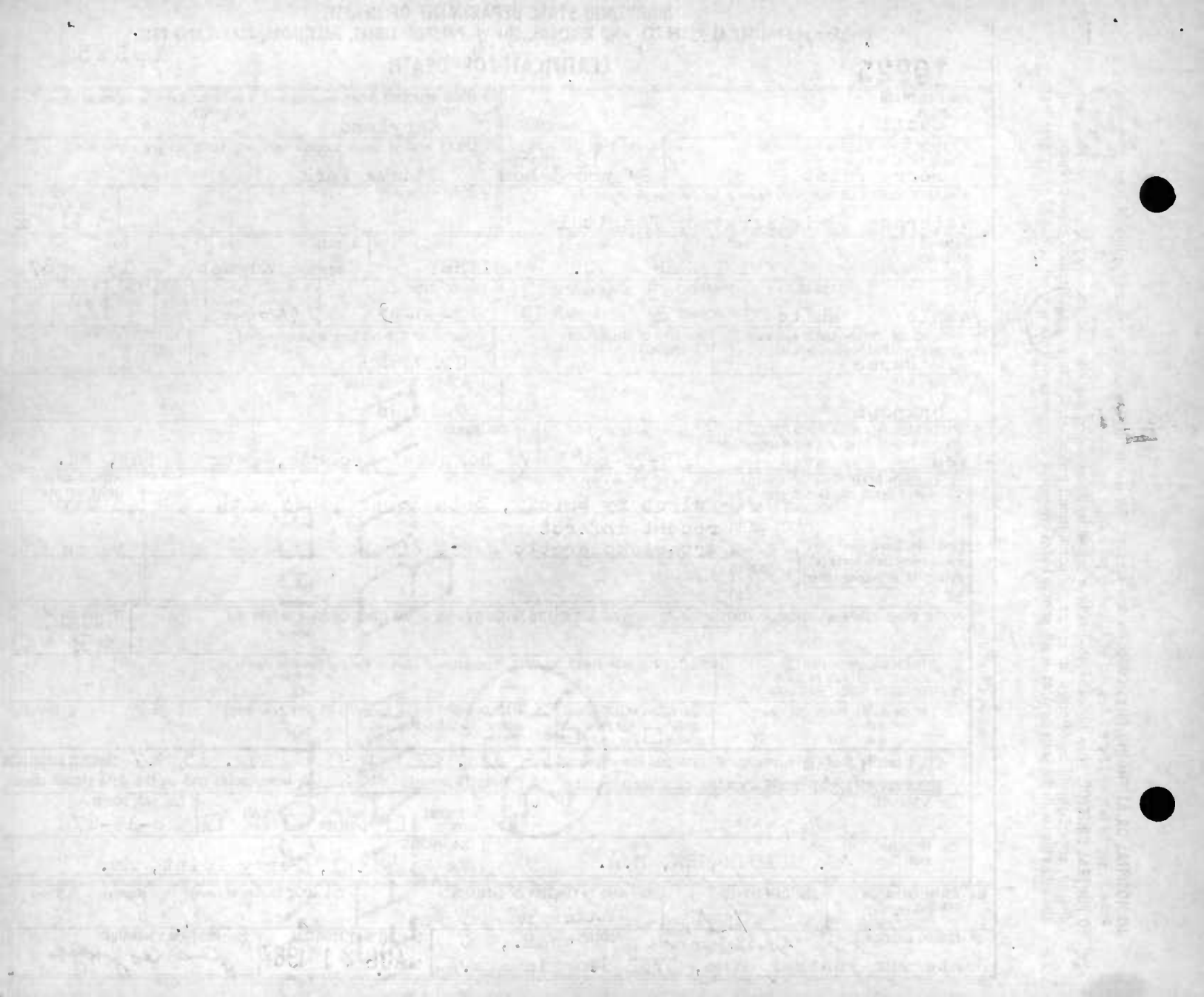
10925

10925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>12 days</b> <b>24 yrs 3 mos</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WINIFRED S. WHITNEY</b>		4. DATE OF DEATH Month Day Year <b>August 15 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-30-92</b>
9. AGE (In years last birthday) <b>74 73 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>479-28-6183</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emboli, both lower lobes with</b> DUE TO <b>recent infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Jan. 22</b> , 19 <b>43</b> , to <b>Aug. 15, 1967</b> , <del>that the deceased</del> <b>and that death occurred at 8:10 am</b> from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>8-15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Burlington Natl Cen</b>	23d. LOCATION (City or Town) (County) (State) <b>Burlington Va</b>
24. FUNERAL DIRECTOR <b>Huntemann Funeral Home, 5732 Georgia Ave. NW</b>		25a. REC'D BY REGISTRAR <b>AUG 21 1967</b>	25b. REGISTRAR'S SIGNATURE 



10926

CERTIFICATE OF DEATH

10926

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Port Deposit</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Port Deposit</u>		07/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 222</u>				d. STREET ADDRESS <u>Rt. 222</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Williams</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1854</u>	9. AGE (In years last birthday) <u>113</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mose Nesbitt</u>				14. MOTHER'S MAIDEN NAME <u>Malinda (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Lillie Montgomery, Port Deposit, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4222 IMMEDIATE CAUSE (a) <u>Myocardial</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10/28</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 24, 1967</u> to <u>Aug 28, 1967</u> that (I) (we) lost saw the deceased alive on <u>Aug 28, 1967</u> , and that death occurred at <u>10P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Clarence I. Benson</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 29-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson M.D.</u>				22d. ADDRESS <u>Port Deposit, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 31, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Bapt. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson &amp; Son, Perryville, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10927

10927

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boulder Elkton</b> c. LENGTH OF STAY IN 1b <b>Elkton</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital (Elkton)</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Virginia Beach</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Virginia Beach</b> d. STREET ADDRESS <b>4132 First Court Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Otis Lee Williams</b>		4. DATE OF DEATH Month Day Year <b>August 15, 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 30, 1934</b>
9. AGE (In years lost birthday) <b>32 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Norfolk, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Norfolk, Va.</b>	
13. FATHER'S NAME <b>Cecil C. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Asble</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Cecil C. Williams</b>		Address <b>same address</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia complicating Multiple Injuries</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>802X</b> (c) <b>XXXX</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Subj. struck by train</b>	
20c. TIME OF INJURY Month, Day, Year <b>7 8/12 19 67</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>RR Tracks</b>	20f. (City or town) (County) (State) <b>Baltimore, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>8/15/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>8/26/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Memorial Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Va. Beach, Virginia</b>
24. FUNERAL DIRECTOR <b>Wm. F. Tuckman</b>		25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>	
ADDRESS <b>Baltimore, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles J. J.</b>	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]

Re New York letter to Bureau dated 10/10/50.  
Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

The above information was obtained from a confidential source who has provided reliable information in the past.  
Very truly yours,  
[Illegible Signature]

Enclosure  
[Illegible Stamp]

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge  
[Illegible Stamp]